U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 August 2006

CASE No.: 2004-BLA-5996

In the Matter of

D. B.,
Claimant and survivor of
W. B.,
Miner

v.

MOUNTAIN LAUREL RESOURCES CO.,
Employer

and

WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

James M. Phemister, Esq.
Wes Garrell, student caseworker
For the Claimant

Christopher M. Hunter, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for survivor's benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). (DX-1)[1]. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

ISSUES

(1) Whether Miner had pneumoconiosis;

(2) Whether Miner's pneumoconiosis arose out of his coal mine employment; and

(3) Whether Miner's death was due to pneumoconiosis.

PROCEDURAL HISTORY

Miner died on January 14, 2003. (DX-8). Claimant filed the present claim for survivor benefits on March 4, 2003. (DX-3). A Proposed Decision and Order was issued on October 24, 2003 denying benefits because Claimant did not establish that Miner's death was due to pneumoconiosis. (DX-14). Claimant requested a hearing before the Office of Administrative Law Judges (OALJ), and the matter was transferred to the OALJ on March 16, 2004. (DX-21). I held a hearing in the matter on April 25, 2006 in Beckley, West Virginia. At the hearing, I admitted into evidence Director's exhibits 1 through 23 (TR 6), Employer's exhibits 1 through 3 (TR 17), and Claimant's exhibits 1 through 11 (TR 15). I held off on ruling on the admissibility of Claimant's exhibits 12 and 13 at the hearing, but I now find that Claimant's exhibit 12 is admissible but that Claimant's exhibit 13 is not.

Employer argued at hearing that Dr. Koenig's report (CX-12) and his supplemental report (CX-13) were inadmissible because Dr. Koenig reviewed medical evidence from the living miner's claim that was not identified and not admitted into evidence in the survivor's claim. Pursuant to *Church v. Kentland-Elkhorn Coal Corp.*, BRB Nos. 04-0617 BLA and 04-0617 BLA-A (Apr. 8, 2005) (unpub.), exhibits from the living miner's claim must be specifically designated by the parties to be admitted in the survivor's claim and are subject to the evidentiary limitations in § 724.414. Dr. Koenig reviewed 4 x-rays, 2 pulmonary function studies, 2 blood gas studies, a Department of Labor exam, and a report by Dr. Zaldivar that have not been

[1] The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, and TR = Transcript of the April 25, 2006 hearing.

admitted into the survivor's claim.[2] While I admitted Director's exhibit 1 (the living miner's claim) into evidence, the medical records contained within DX-1 are not being considered in determining whether Claimant has established entitlement to benefits. I find the medical records have little evidentiary value because they are dated approximately 20 years prior to Miner's death.

However, I find that Dr. Koenig's report is still admissible despite this review of inadmissible evidence. The Board in *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1047 (2004)(*en banc)*, found that the Administrative Law Judge (ALJ) did not abuse his discretion when he refused to consider a physician's opinion on the existence of pneumoconiosis because the ALJ found that this aspect of the opinion was "inextricably tied" to an inadmissible x-ray. I do not find that Dr. Koenig's report is "inextricably tied" to the evidence listed above which has not been admitted in the survivor's claim with the exception of section 5 regarding his diagnosis of clinical pneumoconiosis. Although the not admitted evidence is included in the list of records reviewed for his opinion, I find that Dr. Koenig's report makes particular reference and takes particular note of the studies and tests from the 1990's up to miner's death and not those from the living miner's claim which are from the 1980's. I find that Dr. Koenig's report also relies on the various other records including the medical records and death certificate in rendering his decision. Ultimately, I find that any consideration that Dr. Koenig gave to the records not admitted from the living miner's claim has a *de minimus* effect on his opinion regarding Claimant's COPD. Further evidence of the *de minimus* effect is that the records from the living miner's claim reflect a far less serious pulmonary problem than those from the 1990's up to miner's death. Finally, I find that Dr. Koenig's opinion on whether Miner's death was caused by pneumoconiosis is not affected by any medical records from the living miner's claim. Therefore, I now admit Claimant's exhibit 12, excluding section 5, into evidence.

Conversely, I find that Claimant's exhibit 13 is not admissible. Although Claimant characterized this exhibit as a rehabilitative report, I find that it has little rehabilitative value. Pursuant to § 725.414(a)(2)(ii), "Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." Dr. Koenig's additional statement addresses only Dr. Crisalli's report, which is admitted as Employer's initial evidence and not as rebuttal evidence. I find Dr. Koenig's additional statement fails to explain his conclusions in light of any rebuttal evidence. Dr. Koenig's additional statement attacks and criticizes Dr. Crisalli's opinions. Dr. Koenig's statements referencing his own conclusions are made in rebuttal to Dr. Crisalli's statements and do not provide any additional clarity on Dr. Koenig's original opinion. Therefore, I find this supplemental report is not admissible.

In Employer's brief, he argues that Claimant's request for a hearing before the OALJ is untimely. He argues, therefore, that the District Director's decision denying benefits should be final or, alternatively, then the liability should be transferred to the trust. This matter was transferred to the OALJ on March 16, 2004; Employer waited over two years to raise this issue.

[2] All other evidence considered has been admitted through Claimant's exhibits or has been admitted by virtue of it being designated from the living miner's case on Employer's evidence summary form.

I find that Employer's failure to raise this issue at the time this matter was transferred to my office or at least by the April 25, 2006 hearing constitutes a waiver.

Witness Testimony

Claimant's daughter testified at the hearing as to Miner's condition prior to his death. She stated that it was strenuous for him to pick up his granddaughter, that he had stopped driving in 1995, that he could not carry in the groceries, that he was limited in the chores that he could perform around the house, and that his quality of life had gone down. She testified that he had been using oxygen at night and went on oxygen full time in August of 2002. She testified that he was unable to bathe and could not put on his socks or shoes. She stated that after Miner began using oxygen full time, he rarely ever left the house. She also stated that Miner smoked cigarettes at a rate of about one-half pack per day or less after 1981 and that he never smoked more than one pack per day. Claimant testified that she had to help Miner dress and bathe. She stated that he began smoking in 1945 shortly before they married but that he stopped smoking in 1993. (TR).

Medical Evidence

Chest X-ray

Exhibit	**X-ray Date**	**Physician/ Qualifications**	**Interpretation**
CX-5	1/12/999	Sutliff	Lungs overinflated evidenced by flattening of diaphragmatic leaves, interstitial markings are prominent, no signs of pneumonia or congestive heart failure. Impression: shows findings of chronic lung disease.
CX-6	10/1/02	Daniel	Lungs are hyperaerated, scattered reticulonodular densities throughout lungs are consistent with pneumoconiosis with no evidence of focal infiltrate, effusion or heart failure. Impression: stable chest exam with pneumoconiosis and atherosclerotic heart disease being the predominant findings. An element of COPD is present.

Pulmonary Function Studies

Exhibit	Date	Age / Height	FEV1	FVC	MVV	FEV1/ FVC	NOTES
DX-1	3/12/86	61 67"	2.22 2.68*	4.04 4.67*	80 101*	55%	Moderate reversible obstruction compatible with asthma. Mild diffusion impairment of emphysema.
CX-11	11/05/93	68	1.62	3.17		51.2%	Moderate obstructive ventilatory pattern.
CX-2	5/23/94		1.12 1.73*	2.80 4.27*			This patient's breathing is severely impaired.
CX-7	1/10/95	69 69"	1.18 1.48*	2.81 3.31*	42	42% 45%*	
CX-8	1/12/99	73 68"	1.08 1.08*	2.47 2.63*	32	44% 41%*	

* results after bronchodilator

Arterial Blood Gas Studies

Exhibit	Date	PCO2	PO2	NOTES
DX-1	3/12/86	31 30*	76 81*	Normal resting and exercise
CX-1	1/30/95	40.5	72.9	

* results after exercise

Physicians' Reports and Treatment Records

Med-Surg Group

Treatment records range from April 23, 1993 through March 16, 1994. On April 23, 1993, Dr. McKelvey recorded that Miner was "having no problems with his COPD." Throughout the records there are complaints of dyspnea, cough, congestion, shortness of breath, and wheezing. The records reflect numerous prescriptions for inhalers with frequent changes to control Miner's symptoms and occasional treatments with injections. Dr. McKelvey noted on October 18, 1993 that Miner was having "a lot more shortness of breath and I think that this is exacerbation of COPD rather than CHF." She noted that the x-ray showed no signs of congestive heart failure but that Miner was found to have pulmonary interstitial fibrosis consistent with coal workers' pneumoconiosis. At this time, she recommended hospital admission but Miner declined. He received treatments, and two weeks later he reported feeling much better. Similar reports of exacerbation of COPD were recorded in January and March of 1994 with improvement reported in March 1994. The records reflect a medical history of COPD, coal workers' pneumoconiosis, aortic stenosis, hypertension, prostatic hypertrophy, and reflux esophagitis. Miner's occupation history was recorded as 35 years working in the coal

mines and quitting in 1982. Miner's smoking history was recorded as one-half pack of cigarettes per day for 40 years. (CX-11).

Dr. McKelvey completed a Department of Labor medical necessity form dated September 8, 1994. It requested a nebulizer with motor for ventolin premixed every 6 hours. The prescription duration was from June 16, 1994 through June 15, 1995, and Dr. McKelvey explained "patient's breathing is severely impaired." (CX-2).

Dr. Norma J. Mullins

Dr. Mullins completed two DOL medical necessity forms dated December 30, 1998 and March 14, 2000. The 1998 prescription was from February 13, 1998 through February 12, 1999 for an O_2 concentrator and AC/DC nebulizer with battery adapter. The 2000 prescription was from March 10, 2000 through "lifetime." Both forms stated that patient's breathing was severely impaired, and the 2000 form instructed that nebulizer treatments were to be taken every six hours as needed. (CX-3, 4).

Treatment records from Dr. Mullins range from January 1995 through Miner's death. The treatment records included several pages of handwritten notes which are difficult to read in some spots and illegible in others. Dr. Mullins' first record of January 10, 1995 noted, "[Miner] had an episode of shortness of breath about four or five years ago, but did relatively well up until about a year and half ago and has had continued problems since." She noted that the shortness of breath is fairly marked and that Miner was having difficulty with chores of personal hygiene. She recorded that Miner was on oxygen and had a nebulizer in the home with Albuterol but that he was not using this on a regular basis. She found decreased breath sounds bilaterally during her physical examination of Miner. Her assessment at this time included, "COPD probably on the basis of coalworkers' pneumoconiosis and asthma." She stated that he probably did not need to have the oxygen kept in the home. Dr. Mullins recorded Miner's coal mine employment as 33.5 years or more and his smoking history as one pack per day for 37 years. A later notation states 47 years of smoking.

Miner returned every few days to every month throughout 1995. Dr. Mullins recorded continued problems with improvements after treatments, including notes that Miner felt better when he used oxygen. Occasionally, Miner would be seen as a walk-in for exacerbation of his COPD. In May 1995, he reported having increased difficulty with a change in the weather and a few weeks later he reported feeling better. In June 1, 1995, Miner complained of having quite a bit of problems with shortness of breath. On exam, he had diffuse wheezes but his oxygen saturation was 95%. On June 7, 1995, Miner reported feeling better, but on exam, Dr. Mullins found him to have very diffuse wheezing, poor air entry and noted "he certainly is not improved by much." Records throughout 1995 report difficulty stabilizing Miner's breathing, which would worsen and then improve after treatments or a change in medication. On November 2, 1995, Dr. Mullins recorded that Miner was doing "pretty well overall. He is short of breath, but he is learning how to deal with it."

Records in 1996 reflect typically monthly visits with numerous changes in Miner's prescriptions and reports of a worsening and improving in Miner's breathing. A June 3, 1996

record noted, "We had him hospitalized with exacerbation of his asthma." Miner's O2 saturation was 97% on July 11, 1996.

Over the period from 1997 through the first half of 2002, Miner initially was seen every month and improved to visits every three to six months. Records reflect that Miner's breathing was "fair," "fairly well; some worse days but generally much better," "good and bad days," "about the same," "stable," and "relatively well." His O2 saturation on July 23, 1997 was 94%, and on April 2, 2002 it was 90%. Dr. Mullins noted that they have stabilized his disease progression and that Miner has also learned how to better handle his symptoms. The records reflect frequent assessment and diagnoses of COPD and CWP.

On July 31, 2002, Miner appeared for a walk-in visit. He complained of shortness of breath on exertion. His respiratory exam was diminished throughout but clear. He also complained of what he described as staring spells with confusion. Records note, "When patient walks his O2 sat dropped to 86-87%. ABG PO2 is 50%." Miner was instructed to take oxygen as needed throughout the day and to wear the nasal cannula at night while he slept. Miner was also treated for staring episodes, blurred vision, and slurred speech. An August 6, 2002 record noted that Miner was on oxygen and wearing it, and "his oxygen level is not getting low at times."

Miner's last visit to Dr. Mullins' office was on December 9, 2002. His O2 saturation was recorded as 92%. Dr. Mullins noted that Miner seemed to be doing fairly well. His respiratory exam showed diminished breath sounds. Dr. Mullins wrote a letter dated August 27, 2003. She stated,

> [Miner] did have black lung. As a result of that he had COPD, and that was a direct contributing cause to his death. I stated this on his death certificate and this is certainly as a [sic] simple as I can continue to make it.

(CX-1).

Dr. Steven Koenig

Dr. Koenig rendered an opinion dated February 9, 2006 at the request of Claimant. Dr. Koenig is board-certified in internal medicine, pulmonary diseases, critical care medicine, and sleep medicine. Dr. Koenig recorded Miner's history as including: coal mine employment of approximately 35 years from 1946 through 1981; medical history including CWP, severe, oxygen dependent COPD, hypertension, hypercholesterolemia, peptic ulcer disease/gastroesophageal reflux disease, osteoarthritis, anxiety, panic attacks, depression, possible dementia, and benign prostatic hypertrophy; and, smoking history of one-half pack of cigarettes a day for approximately 47 years.

Dr. Koenig reviewed the medical records admitted in this claim[3] and, as discussed above, records from the living miner's claim. He discussed the most likely explanations for Miner's obstructive pulmonary function tests to be COPD, including chronic bronchitis, and asthma. He favored the diagnosis of COPD over that of asthma because of the low diffusing capacity for carbon monoxide (DLCO), the increased RV/TLC, and the incomplete reversibility of airflow obstruction with bronchodilator. He noted that with asthma, the airflow obstruction is classically completely reversible and the DLCO is normal.

Dr. Koenig opined that Miner had severe impairment secondary to COPD. Having considered Miner's last employment in the coal mines, Dr. Koenig opined that Miner would have been totally and permanently disabled from performing this occupation.

Dr. Koenig opined that Miner's COPD was secondary either to cigarette smoking, coal dust exposure, or a combination of the two. Dr. Koenig cited to numerous studies to support his position that coal dust exposure can cause severe and disabling COPD even in the absence of radiographic evidence. He also cited to studies to demonstrate that the type of COPD that is secondary to coal dust exposure is indistinguishable from that caused by cigarette smoking. He concluded that when a miner has significant exposure to both coal mine dust and cigarette smoke, it is often impossible to determine whether the coal dust or the cigarette smoking was the exclusive cause. He opined in those circumstances, the only sound medical diagnosis is that neither can be excluded as a cause and so both must be included as a cause. Therefore, Dr. Koenig concluded, "[Miner's] exposure to coal dust unquestionably contributed significantly to his COPD." He stated that it would be an improper medical judgment to claim that Miner's respiratory disability was only due to cigarette smoking because it would disregard the "numerous methodologically valid studies in the medical literature as well as the opinions set forth by NIOSH, the Industrial Injuries Advisory Council of Great Britain (IIAC) and numerous experts in the field of Occupational Lung Disease."

Dr. Koenig opined that Miner died of a cardiac arrest with the terminal event being a cardiac arrhythmia, either ventricular fibrillation or asystole. Dr. Koenig cites to medical literature to support his position that a reduced FEV1 is an independent risk factor not only for death, but for cardiovascular events such as myocardial infarction and arrhythmias. He noted that Miner not only had a decreased FEV1, but a severely diminished FEV1 value. He stated that the cause of this severely diminished FEV1, which according to Dr. Koenig increased his risk of dying from a cardiac arrhythmia, was COPD. He also opined that severe COPD itself is associated with increased mortality and stated that Miner's COPD was of sufficient severity to hasten his death. Dr. Koenig concluded that Miner's coal dust exposure caused or at least significantly contributed to Miner's COPD and the resultant severely decreased FEV1, that Miner's severe COPD and decreased FEV1 caused or at least significantly contributed to the terminal cardiac arrhythmia, and that "[c]onsequently, [Miner's] coal mining employment caused, contributed to, or at the very least hastened his death." (CX-12).

[3] Dr. Koenig did not review Dr. Crisalli's report in rendering his original report admitted in CX-12. His supplemental report (CX-13) addressed Dr. Crisalli's report, but as stated above I did not admit that supplemental report.

Dr. Robert J. Crisalli

Dr. Crisalli issued a report dated March 21, 2006. Dr. Crisalli is board-certified in internal medicine and pulmonary diseases. Dr. Crisalli reviewed Miner's records from 1993 to his death. Dr. Crisalli also reviewed Miner's employment records, the 1977 Occupational Pneumoconiosis Board findings, and the reports of Drs. Mullins, Fino, and Koenig. Dr. Crisalli opined that there is "some evidence" suggesting that Miner had coal workers' pneumoconiosis. He found some, but not all, of the x-ray interpretations indicate the presence of changes consistent with coal workers' pneumoconiosis. He noted that the primary findings on x-ray were hyperinflation and flattened diaphragm, which Dr. Crisalli opined is consistent with a diagnosis of emphysema and with the pulmonary functions studies showing a severe obstruction to airflow with air trapping. Dr. Crisalli opined that this type of emphysema is not seen as a result of coal dust exposure but rather in individuals who have emphysema secondary to heavy cigarette smoking. Dr. Crisalli concluded that although there was some evidence to suggest the presence of simple coal workers' pneumoconiosis, he felt it was clear that Miner's pulmonary function impairment was secondary to his heavy cigarette smoking history.

Dr. Crisalli concluded that Miner was unable to perform his regular coal mine employment from a respiratory standpoint. However, he opined that coal dust exposure played no role in Miner's disability prior to death. Finally, Dr. Crisalli opined that neither coal dust exposure nor coal workers' pneumoconiosis played any role in Miner's death and did not hasten his death. Dr. Crisalli stated that Miner had asthma based on his response to bronchodilators in the pulmonary function studies and based on Miner's pulmonary physician's treatment of him as an asthmatic with steroids and certain other medications. (EX-2).

Dr. Crisalli testified at a deposition on April 17, 2006. He discussed the medical records from Dr. Mullins. He noted that Dr. Mullins described Miner as doing fairly well shortly before his death. He concluded that Dr. Mullins treated Miner with various medications that are for asthma and are not for COPD or lung diseases related to coal dust exposure. He noted that the pulmonary function studies support an asthma-related obstruction despite not reversing completely after bronchodilators, which he stated was not necessary for a diagnosis of asthma and varied depending on severity. Dr. Crisalli testified that coal dust exposure cannot be an aggravating factor in asthma after coal dust exposure had ceased. He attributed Miner's severe obstruction to emphysema and stated that he attributed Miner's emphysema to smoking and not to coal dust exposure. Dr. Crisalli opined that based on the treatment records he reviewed, the treatment records do not support the cause of death being attributed to COPD or coal workers' pneumoconiosis. He found no respiratory decline or increase in symptoms prior to Miner's death that would allow him to conclude that one month later he would have died as a result of a respiratory process or disease. Dr. Crisalli stated that one would expect to see a history of hospitalizations or emergency room visits leading up to a point where the patient and family knows that the patient would pass away soon.

He opined, "If he died a sudden death, it's more logical to conclude that he died a non-respiratory death from a disease that affects the general populations, such as coronary artery disease." He concluded, "Something catastrophic and sudden happened, but there's no way to know what the disease process was that caused his sudden death. I can reliably state what the

cause of death was not, that it was not his respiratory disease." Dr. Crisalli also responded to a question regarding the possibility of his respiratory impairment increasing the burden on the heart causing his heart to give out early. He stated, "If the individual's oxygen were low or represented an acute change, this could create a strain on the heart. But [Miner's] oxygenation was such that Doctor Mullins herself indicated that he did not need oxygen therapy. . . . but a PO2 in the seventies for an individual of [Miner's] age correlates with an oxygenation saturation or hemoglobin saturation that's well in the nineties. . . . based on the information in the record, he had enough oxygenation."

Dr. Crisalli acknowledged that there is some radiographic evidence of coal workers' pneumoconiosis but that there was a difference of opinion regarding the x-ray. He stated that it is possible that Miner had simple coal workers' pneumoconiosis. (EX-3).

Dr. Gregory J. Fino

Dr. Fino rendered an opinion dated February 17, 2004 at the request of Employer. Dr. Fino's report stated that he reviewed Miner's employment history and two medical records: the January 14, 2003 terminal emergency department visit and the death certificate. According to Dr. Fino, there is no evidence in the medical record as to the cause of death other than the fact that Miner's lungs and heart stopped. Dr. Fino opined that the cause of death appeared natural and that there was no evidence of lung disease of any type. Dr. Fino found no evidence of coal workers' pneumoconiosis and no evidence in the medical record that he died as a result of any type of lung disease. Dr. Fino concluded that even if he were to assume that coal workers' pneumoconiosis were present in Miner, "there is no evidence whatsoever that coal workers' pneumoconiosis caused, contributed to, or hastened his death." (EX-1).

Plateau Medical Center

According to records, on January 14, 2003, Miner was found unresponsive sitting in a chair. EMS was called and that upon arrival by EMS, Miner was in full cardio-respiratory arrest. CPR was not administered until EMS arrival. Emergency Room Department notes record Miner in cardiac arrest, asystole on monitor. Medications were given in the Emergency Room, but Miner was pronounced dead. (DX-9).

Death Certificate

The death certificate was certified by Dr. Norma Mullins. Dr. Mullins listed the immediate cause of death as cardiorespiratory arrest due to COPD due to CWP. Dementia is listed as an "other significant condition." (DX-8).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the hearing, the parties conceded that Miner had 35 years of coal mine employment, that Claimant is an eligible survivor, that Mountain Laurel Resources is the properly named Responsible Operator, that the date of the application is March 4, 2003, and that Miner's date of death is January 14, 2003. (TR 18-20).

Length of Coal Mine Employment

Parties concede that Miner had 35 years of coal mine employment. (TR 18). The District Director found 33 years, 6 months. (DX-13). I find that the records are consistent with approximately 33 years and 6 months of coal mine employment. (DX-4, 5, 6).

Responsible Operator

The parties agree, and I find that Mountain Laurel Resources is properly named as the Responsible Operator.[4] (TR 19).

Smoking History

Based on the histories recorded in Miner's treatment records and witness testimony at the hearing, I find that Miner smoked for approximately 47 years at a rate of ½-pack per day.

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Amendments to the Part 718 regulations became effective on January 19, 2001. As this claim was filed on March 4, 2003, such amendments are applicable.

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the Claimant must prove that the Miner had pneumoconiosis; that his pneumoconiosis arose out of coal mine employment; and, that the Miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a).

In order to establish that a Miner's death was due to pneumoconiosis, the Claimant must establish at least one of the following criteria:

> (1) Where competent medical evidence establishes that the miner's death was due to pneumoconiosis; or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or where death was caused by complications of pneumoconiosis; or
>
> (3) Where the presumptions set forth in § 718.304 regarding complicated pneumoconiosis is applicable.

§ 718.205(c).

[4] Claimant's last coal mine employment was in West Virginia. The Benefits Review Board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989). Because Claimant's last coal mine employment took place in West Virginia, the jurisdiction of the United States Court of Appeals for the Fourth Circuit applies.

Pneumoconiosis is a substantially contributing cause of a miner's death if it hastens the miner's death. 20 C.F.R. § 718.205(c)(5). The circuit courts developed the "hastening death" standard, which has been incorporated into the amendments to the Regulations. This standard requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. In a survivor claim, a threshold determination as to the existence of pneumoconiosis must first be made. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-84 (1993). Such is the case here, and therefore, the evidence will be reviewed in order to ascertain whether Claimant can meet this initial burden of proof.

Existence of Pneumoconiosis

Miner had applied for federal benefits during his lifetime. (DX-1). Benefits were awarded when Employer withdrew its controversion and requested a remand for an entry of an award for benefits commencing from May 1984. (CX-10). Miner was also receiving state benefits from West Virginia. (CX-9). At the hearing, parties discussed whether collateral estoppel would apply in this matter to preclude the West Virginia Coal Workers' Pneumoconiosis Fund from relitigating the issue of whether Miner suffered from pneumoconiosis based upon Employer's withdrawal of controversion in the living miner claim. I find that collateral estoppel does not apply under these circumstances.

Howard v. Valley Camp Coal Co., 94 Fed.Appx. 170 (4th Cir. April 14, 2004) (unpublished), addressed a similar situation. The court in *Howard* decided that a change in the law occurred following the decision of *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), which prevented the application of issue preclusion in the survivor's claim. Thus, because Miner was awarded benefits prior to the *Compton* decision and because Claimant's application for survivor benefits must be decided pursuant to the weighing of evidence as set forth in *Compton*, I find that collateral estoppel does not apply and the West Virginia Coal Workers' Pneumoconiosis Fund is not precluded from relitigating the issue of pneumoconiosis.

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal mine employment. *Id.* A

claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that the Miner had pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). As Claimant is not eligible for the presumptions[5] and no biopsy or autopsy evidence appears in the record, only chest x-rays and medical opinions can establish the existence of pneumoconiosis in this claim. In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pursuant to 20 C.F.R. § 718.202(a)(1), the existence of pneumoconiosis can be established by means of x-ray evidence. There are only two x-rays that were admitted in this matter. Both x-rays were read for medical treatment purposes and not for the purposes of establishing the presence of pneumoconiosis. Neither interpretation provided a profusion rating. The regulations provide that "no chest X-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of (§718.102) and Appendix A." 20 C.F.R. §718.102(c) (2001). These x-rays do not comply with quality standards of the regulations, and although there is some evidence of a positive interpretation of pneumoconiosis, I cannot find that these x-rays are sufficient to establish clinical pneumoconiosis by a preponderance of the evidence. Thus, Claimant has failed to establish clinical pneumoconiosis by x-ray evidence.

A determination of the existence of pneumoconiosis also may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion, finds that the Miner suffered from pneumoconiosis. 20 C.F.R. § 718.202(a). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A

[5] Claimant is ineligible for the § 718.304 presumption because the Miner was not diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because the claim was not filed before January 1, 1982, and Claimant is ineligible for the § 718.306 presumption because the Miner did not die on or before March 1, 1978.

medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983). A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Id.*

In determining which medical opinions are to be accorded the greater weight, the qualifications of the physicians are relevant in assessing the probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 C.F.R. § 718.104(d).

In assessing whether Miner had pneumoconiosis, I find that the reports of Drs. Koenig and Crisalli are the most relevant. While I am inclined to give Miner's treating physician, Dr. Mullins, considerable weight, I cannot find that her medical records or August 27, 2003 statement rises to the level of being well-reasoned and well-documented. Therefore, her opinion by itself is insufficient to support a finding of pneumoconiosis. Dr. Fino's report of February 17, 2004 focuses on Miner's cause of death and was very limited in the records reviewed, and I find that it provides no assistance in determining whether Miner had pneumoconiosis.

In assessing the opinions of Drs. Crisalli and Koenig, I note the disagreement about Miner's pulmonary diagnoses and the cause of Miner's emphysema. Dr. Crisalli's diagnosis of asthma was refuted by Dr. Koenig, who supported his position with objective test results and citations to medical literature. I find Dr. Koenig's opinion on this matter to be better reasoned because I am concerned that Dr. Crisalli's diagnosis was heavily based on Miner's medication treatments. While the records do mention asthma and a diagnosis of "COPD probably on the basis of coalworkers' pneumoconiosis and asthma," Dr. Mullins' statement and the death certificate attribute Miner's COPD due to CWP or black lung.

Furthermore, I credit Dr. Koenig's position that the type of COPD secondary to coal dust exposure is indistinguishable from that caused by cigarette smoke. Dr. Koenig supported his reasoning by which he concluded that both cigarette smoke and coal dust exposure were causes of Miner's COPD by numerous citations to medical literature. Despite having read Dr. Koenig's report prior to preparing his report, Dr. Crisalli never addressed why this position was incorrect and why his position that Miner's emphysema was of a type not consistent with coal dust exposure was correct. Furthermore, Dr. Crisalli provided no medical literature to support his

position. Thus, I credit greater weight to Dr. Koenig's opinion as I find it to be better reasoned and better documented.

Crediting greater weight to Dr. Koenig's opinion, I find that Claimant has established that Miner had legal pneumoconiosis. Weighing all the evidence together, I find that the medical evidence establishes the existence of legal pneumoconiosis pursuant to § 718.202.

Cause of Pneumoconiosis

In order to be found eligible for benefits, Claimant must establish that the Miner's pneumoconiosis arose out of coal mine employment. *See* 20 C.F.R. § 718.203(a). Pursuant to 20 C.F.R. § 718.203(b), if a miner who was suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. I found that Miner worked for 33 years and 6 months as a coal miner. Thus, Claimant is entitled to the presumption. I find that that presumption has not been rebutted and that Claimant has established that the Miner's pneumoconiosis arose out of coal mine employment.

Death Due to Pneumoconiosis

The standard to be utilized in determining whether death was due to pneumoconiosis has been detailed above. The evidence regarding cause of death includes the death certificate, a statement by Dr. Mullins, and the reports of Drs. Fino, Crisalli, and Koenig.

A death certificate, in and of itself, is an unreliable report of the miner's condition. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). The Board has held that a physician's opinion expressed on a death certificate in addition to his testimony is sufficient to establish the cause of the miner's death. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988). The death certificate indicated that Miner died due to cardiorespiratory arrest due to COPD due to CWP. Dr. Mullins, Miner's treating physician, authored the cause of death, and therefore, she had substantial personal knowledge of Miner's medical conditions from which to assess the cause of death. Dr. Mullins did issue a statement reaffirming her opinion on the cause of death. Nevertheless, I find that this statement is not a well-reasoned report as it does not explain the reasoning by which Dr. Mullins came to her conclusions. Thus, I find that the death certificate and Dr. Mullins' statement are insufficient to establish Miner's cause of death.

An opinion may be given less weight where the physician did not have a complete picture of the miner's condition. *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). Dr. Fino reviewed only the January 14, 2003 Emergency Room record and the death certificate in rendering his opinion. I find that he lacked critical information of Miner's pulmonary condition in assessing whether Miner's pneumoconiosis caused, contributed to, or hastened Miner's death. Thus, I credit little weight to Dr. Fino's report.

Drs. Crisalli and Koenig both provided well-reasoned reports and deserve consideration. However, I credit greater weight to Dr. Koenig's opinion. In Dr. Crisalli's report and deposition

testimony, he relied on Dr. Mullins' records that Miner was doing "fairly well" and that she did not feel Miner needed oxygen therapy. I disagree with Dr. Crisalli's review of Dr. Mullins records finding that he overlooked certain aspects of her records. While Dr. Mullins did state that Miner did not need oxygen therapy in 1995, in July 2002 Miner had a PO2 of 50% and was put on oxygen as needed throughout the day. I do not interpret Dr. Mullins' statements of "pretty well" to mean that Miner felt well. Her November 2, 1995 record stated that Miner was doing "pretty well overall. He is short of breath, but he is learning how to deal with it." I find that Dr. Mullins' reports indicate that Miner had learned to live with his severe pulmonary impairment. Witness testimony described how Miner had modified his lifestyle and how his condition declined after he went on oxygen full-time. Furthermore, Drs. McKelvey and Mullins recorded several episodes of an exacerbation of COPD in which Miner's condition deteriorated within a short period of time. Finally, Dr. Crisalli did not diagnose legal pneumoconiosis, which I found Claimant established by a preponderance of the evidence. Finding Dr. Crisalli's opinion to be contrary to my findings and inconsistent with the medical record and witness testimony, I credit less weight to his opinion.

Dr. Koenig's report relied on Miner's objective test results along with citations to medical literature in rendering his conclusion that Miner's COPD and resultant severely decreased FEV1 "caused, contributed to, or at the very least hastened [Miner's] death." I find this to be a well-reasoned and well-documented report. Furthermore, I find the death certificate and Dr. Mullins' records and statement, although insufficient alone, lend credence to Dr. Koenig's conclusions. Of all the evidence relevant to the issue of whether death was due to pneumoconiosis, I find Dr. Koenig's report is entitled to the most weight.

I find that death was, in fact, contributed to and hastened by legal pneumoconiosis. Accordingly, I find that Claimant has met her burden of proving that coal workers' pneumoconiosis contributed to the Miner's death pursuant to 20 C.F.R. § 718.205(c).

Entitlement

Because Claimant has established that the Miner's death was due to pneumoconiosis, she is entitled to benefits under the Act. Benefits are payable as of the month in which the Miner died, January 2003.

ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. *Bankes v. Director*, 8 BLR 2-l (l985). The application must conform to 20 C.F.R. 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

It is ordered that the claim of D. B. for benefits under the Black Lung Benefits Act is hereby GRANTED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).